

| | | | | | |
|--|---|---|---|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395380 | (X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____ | | (X3) DATE SURVEY COMPLETED: 03/28/2023 |
| NAME OF PROVIDER OR SUPPLIER: SAUNDERS NURSING AND REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE: 100 LANCASTER AVENUE WYNNEWOOD, PA 19096 | | |
| STATE LICENSE NUMBER: 190402 | | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | (X5) COMPLETE DATE |
| F 0000 | <p>INITIAL COMMENT</p> <p>Based on an Abbreviated Survey in response to two complaints, completed on March 28, 2023, it was determined that Saunders Nursing and Rehabilitation Center, was not in compliance with the following requirements of the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations related to the health portion of the survey process.</p> | | F 0000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

Pennsylvania Department of Health

| | | | | | |
|---|--|--|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395380 | (X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____ | | (X3) DATE SURVEY COMPLETED: 03/28/2023 |
| NAME OF PROVIDER OR SUPPLIER: SAUNDERS NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 190402 | | | STREET ADDRESS, CITY, STATE, ZIP CODE: 100 LANCASTER AVENUE WYNNEWOOD, PA 19096 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | (X5) COMPLETE DATE | |
| P 2020 | <p>§ 211.12(i) Nursing services.</p> <p>(i) A minimum number of general nursing care hours shall be provided for each 24-hour period. The total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 2.7 hours of direct resident care for each resident.</p> <p>This REGULATION is not met as evidenced by:</p> | P 2020 | <p>This provided submits the following plan of correction in good faith and to comply with State and Federal regulations. This plan is not an admission of wrong doing nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies.</p> <p>An audit of schedules for 2 weeks has been completed to meet the minimum number of nursing hours of 2.7 hours of direct resident care for each resident.</p> <p>The DON/Scheduler and Nursing Supervisors have been educated on the daily minimum number of nursing hours of 2.7 hours of direct care for each resident by the NHA/designee. The NHA/designee will complete weekly audits times four weeks of daily schedules and monthly times two months to ensure the daily minimum nursing hours of 2.7 hours of direct care for each resident. Results of these audits will be submitted to the Quality Assurance committee to determine if further action is needed.</p> | <p>Completion Date: 04/25/2023 Status: APPROVED Date: 04/14/2023</p> | |
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | | | TITLE: (X6) DATE: | | |
| | | | | | |

Pennsylvania Department of Health

| | | | | | |
|--|---|---|---|--------------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395380 | (X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____ | | (X3) DATE SURVEY COMPLETED: 03/28/2023 |
| NAME OF PROVIDER OR SUPPLIER: SAUNDERS NURSING AND REHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE: 100 LANCASTER AVENUE WYNNEWOOD, PA 19096 | | | |
| STATE LICENSE NUMBER: 190402 | | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | (X5) COMPLETE DATE | |
| P 2020 | Continued from page 1 Based on a review of facility nursing staffing schedules and interview with staff, it was determined that the facility failed to meet the minimum number of nursing care hours for each 24-hour period for four of 21 days reviewed. (March 5, 2023, March 11, 2023, March 12, 2023, March 13, 2023) Findings include: A review of nursing schedules from March 4, 2023, through March 26, 2023, revealed that the facility failed to meet the minimum number of nursing hours of 2.7 hours of direct resident care for each resident on five of seven days reviewed as follows: Sunday, March 5, 2023, was 2.52 hours of direct resident care. Saturday, March 11, 2023, was 2.33 hours of direct resident care. Sunday, March 12, 2023, was 2.40 hours of direct resident care. Monday, March 13, 2023, was 2.67 hours of direct resident care. | P 2020 | | | |

Pennsylvania Department of Health

| | | | | | |
|---|--|---|---|--------------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395380 | (X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____ | | (X3) DATE SURVEY COMPLETED: 03/28/2023 |
| NAME OF PROVIDER OR SUPPLIER: SAUNDERS NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 190402 | | STREET ADDRESS, CITY, STATE, ZIP CODE: 100 LANCASTER AVENUE WYNNEWOOD, PA 19096 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | (X5) COMPLETE DATE | |
| P 2020 | Continued from page 2 An interview with the Nursing Home Administrator, on Tuesday, March 28, 2023, at 2:05 p.m. confirmed that the three weeks of schedules were provided for review, and were as worked for each day requested. 28 Pa. Code 211.12(i) Nursing services | P 2020 | | | |



Certified End Page

SAUNDERS NURSING AND REHABILITATION CENTER

STATE LICENSE NUMBER: 190402

SURVEY EXIT DATE: 03/28/2023

**I Certify This Document to be a True and Correct Statement of Deficiencies and
Approved Facility Plan of Correction for the Above-Identified Facility Survey**

A handwritten signature in black ink that reads "Jeane Parisi".

Jeane Parisi
Deputy Secretary for Quality Assurance

A handwritten signature in black ink that reads "Debra L. Bogen MD".

Debra L. Bogen, MD, FAAP
Acting Secretary of Health



THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY